**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

VICTORIA M VOGE, MD
10109 MCKALLA PLACE, STE E
AUSTIN, TX 78758

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 19

**MFDR Tracking Number**

M4-11-3161-02 formerly M4-11-3161-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The enclosed claim was denied in error. This claim was for a Division ordered Designated Doctor Exam."

**Amount in Dispute:** $850.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** A copy of dispute was placed in carrier rep box on May 20, 2011 with no response to MFDR.

**Response Submitted by:** NA

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 24, 2011 | 99456-W5-NM and 99456-RE-W8 | $850.00 | $850.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - Z212F – 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY. AFTER CAREFULLY REVIEWING THE RESUBMITTED INVOICE, ADDITIONAL REIMBURSEMENT IS NOT JUSTIFIED.

**Issues**

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The respondent has denied a billing based on incorrect information regarding the eligibility for this Requestor to perform the services in dispute. Division records confirm that the requestor is eligible to perform Designated Doctor examinations as well as MMI/IR, therefore, this review will be made according to applicable fee guidelines 28 Texas Administrative Code §134.204.

2. The requestor billed the amount of $850.00 for CPT code 99456-W5-NM for Designated Doctor Examination for the injured worker not being at Maximum Medical Improvement (MMI), therefore no IR was performed. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The requestor also billed $500.00 for CPT code 99456-W8-RE for a Return to Work (RTW) examination. Review of documentation supports that the Division ordered the examinations. Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the MAR for the 1st Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is $500.00. The combined MAR for the RTW and MMI examinations is $850.00. Reimbursement in the amount of $850.00 is therefore recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $850.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $850.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | December 22 , 2011<br>Date |
|---|---|---|

***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.